

TRANSACTIONS

OF THE

NEW YORK SURGICAL SOCIETY.

Stated Meeting, November 8, 1905.

The President, Dr. HOWARD LILIENTHAL, in the Chair.

INTESTINAL OBSTRUCTION; FROM ADHERENT MECKEL'S DIVERTICULUM.

DR. CHARLES L. GIBSON presented a boy, four years old, who was admitted to St. Luke's Hospital on October 21, 1905, with a history dating back five days, when he was seized with sudden vomiting which soon became continuous. No cause for this could be assigned.

When Dr. Gibson saw the boy he was in a condition of collapse, with a temperature of 99 F., and a pulse of 136. The abdomen was much distended. It was opened in the median line, and an obstruction of the lower portion of the ileum was found. The collapsed segment of the gut led to a Meckel's diverticulum, and upon investigation it was found that the obstruction was not caused by the diverticulum itself, but by an adhesion extending from the mesentery to the diverticulum. This was divided, and although the involved section of the gut seemed to be in pretty bad condition, the circulation gradually returned, and the boy made an uneventful recovery. The Meckel's diverticulum was about the size of the last joint of an adult finger, and was situated eight inches from the ileo-cæcal valve.

In reply to a question, Dr. Gibson said he did not remove

the diverticulum, as it was not the direct cause of the obstruction, and as the child was apparently moribund at the time of the operation.

DR. CHARLES N. DOWD asked whether any of the members had ever seen a case where a constriction of the intestine had resulted from the obliteration of Meckel's diverticulum? He had recently operated upon a case in which a constriction existed there. Whether it was temporary or not could not be determined, but it persisted during the half hour that the operation lasted.

DR. ROBERT H. M. DAWBARN said he did not think the complication suggested by Dr. Dowd was ever likely to occur. The diverticulum nearly always sprang from a section of the gut (the ileum) the contents of which, according to Murphy, were invariably fluid. In the large intestine, the contents of which were comparatively solid, obstruction was much more apt to occur. When the Murphy button was first brought out, the objection was made to it that the small opening it left would be apt to become obstructed, while as yet the button had not become detached, and in answer to that criticism, Dr. Murphy published the results of a series of experiments and made the assertion that the contents of the small intestine were invariably fluid, and for that reason obstruction in that region of the bowel, need not be feared.

DR. LILIENTHAL said that a few months ago he was called to see a girl six years old who had just recovered from the whooping-cough, during the course of which she had had attacks of abdominal pain. When the speaker saw her, she had been very sick for two days. The bowels had moved after castor oil. There was some abdominal distention. The temperature was not particularly high, and the child's parents were very much averse to operation. She was, however, sent to the hospital, and immediately after her admission she went into a state of collapse.

Upon opening the abdomen, which was done without delay, Dr. Lilienthal said he came upon a Meckel's diverticulum about five inches long, and characteristic in appearance. It was turned under a fold of mesentery, and adherent somewhere in the right loin. The belly was full of bloody fluid, and the area of gangrene had extended up to the small intestine.

On account of the poor condition of the patient, nothing was

done but to draw the diverticulum into the wound, and make a quick entero-enterostomy with rubber ligature between the two legs of the involved loop. The patient died a few hours after the operation.

In this case, the speaker said, we had an organ much larger than the appendix completely gangrenous, and yet the symptoms were so mild until the child went into collapse that the advisability of an operation was doubtful.

CARCINOMA OF THE MALE BREAST.

DR. GIBSON presented a man, 67 years old, whose previous and family history was unimportant, with the exception of the fact that ever since he could remember he had a small lump in the left breast. Five years ago this had begun to increase in size, and a year later it began to ulcerate.

When the patient was admitted to the hospital, on October 2, of the present year, he presented a large, ulcerating mass firmly fixed to the chest wall. There was marked involvement of the axillary glands, and the outlook did not appear very hopeful. An operation was done, at which, in addition to separating the tumor from the chest wall, it became necessary to remove part of the intercostal muscles. The condition of the patient did not permit of immediate skin-grafting, and the wound was now healing by granulation.

Dr. Gibson said that this was the first case of carcinoma of the male breast upon which he had had occasion to operate. The case was also interesting because it illustrated the fact that benign tumors occasionally became malignant.

Pathological diagnosis: Alveolar carcinoma.

In reply to a question, Dr. Gibson said that he could offer no theory as to the origin of the cancer in this case. There was no history of irritation at the nipple: nothing but the tumor in the upper quadrant of the breast, and that had been there since childhood.

DR. LILIENTHAL said he had operated on one case of carcinoma of the male breast in which the patient distinctly traced the condition to the constant irritation of a suspender-buckle, which occasionally caused his nipple to bleed, and which might have had some etiological bearing. That patient was a man

about thirty years old. He always wore soft flannel shirts, and the buckle of his suspenders rested right over the nipple.

DR. ARTHUR L. FISK said that some years ago he saw a carpenter with carcinoma of the breast which was supposed to have been produced by the pressure of the stock of a bit against his left breast. The breast was excised.

DR. DOWD mentioned a case in an actor who for a long time had played a part in which it was necessary for him to repeatedly strike himself on the breast with his fist.

DR. LILIENTHAL called attention to the fact that these traumas may have only aggravated a pre-existing tumor.

DR. FRED KAMMERER said that he had operated on several cases of carcinoma of the male breast in which the disease proved to be of rather a malignant type.

EXCISION OF THE UPPER JAW.

DR. OTTO G. T. KILIANI presented a girl of twenty years, who developed a hard tumor of the right upper maxilla, which was first noticed about four years ago. The tumor gradually increased in size, and an operation for its removal was undertaken on October 16, 1905. Preliminary to the operation, the right external carotid artery was ligated, and the enlarged glands in the neck removed. He then made a resection according to Kocher, somewhat modified to prevent a disfiguring scar, and extirpated the entire upper right maxilla. There was no resulting facial paralysis, and the cosmetic effect was excellent, and would be further improved by the ultimate insertion of a proper plate. The pathologist reported that the tumor was a fibroma, and absolutely benign.

DR. ROBERT H. M. DAWBARN said in approving of the external carotid ligation performed in this case, the New York Surgical Society had not put itself definitely on record in regard to the advisability of ligation of this artery as a preliminary step to certain otherwise very bloody operations on the face, and that even an excision of the upper jaw was resorted to by some operators without such a preliminary measure. In so prominent a work as "Butlin upon the Surgery of Malignant Growths," that author nowhere advocates preliminary ligations, and seemingly retains as many surgeons still do the fear of secondary hemor-

rhage from the external carotid, if tied; a fear based upon the close order in which its branches are given off—leaving no place for formation of an internal clot. Dr. Dawbarn said he had ligated the external carotid over one hundred times in living subjects, without encountering any secondary hemorrhages at all. The subject had come up for discussion at the recent meeting of the Pennsylvania State Medical Association, at Scranton, and Dr. Crile, of Cleveland, had made the statement that in a few instances sudden death had followed the operation; he did not say, however, that the cause of death in those cases was secondary hemorrhage. Dr. Dawbarn said, that in his opinion, ligation of this artery is, in experienced hands, practically without mortality, and that these were cases in which the internal carotid was tied by mistake. He recalled such a case occurring at the New York City Hospital at his own hands, early in his experience, where the unintentional ligation of the internal carotid by himself in mistake for the external was followed within a few hours after the operation by coma and a rapidly developing lobar pneumonia, with death within two days. This latter strange complication, the speaker said, he had subsequently learned was mentioned by Erichsen in his work upon surgery as an occasional ill-explained result of tying the internal carotid. The only way in which this error could be avoided was to find, before tying, a perfectly frank bifurcation of the common carotid; *i.e.*, one giving off branches in the neck, the other not doing so. In the fatal case for which he had been responsible, Dr. Dawbarn said, an inequality of the pupils was noticed shortly after the operation; and if recognizing promptly the significance of this striking fact, the wound had been immediately re-opened, and the ligature removed, which had been tied of course but gently about the internal carotid, the circulation in the brain might have been restored, and the patient's life probably have been saved.

It seemed to the speaker well worth noting that the commonest anomaly in man, is the rule in dogs: namely, that there is no external carotid, but, instead, the internal on its way to the brain gives off all the branches usually arising from the external carotid. In such a case it is plain that although control of the seeming external carotid would stop the pulse over the facial and superficial temporal arteries, this, the usual test given in the

text-books, would be valueless, might well cost the patient his life, and as a further blunder might easily be recorded by the operator as a death in consequence of ligation of the external carotid.

DR. KAMMERER said the mistake of tying the internal instead of the external carotid, to which Dr. Dawbarn had referred, could be avoided, and therefore did not count against the operation. The speaker said he had resorted to preliminary ligation of the external carotid in a number of operations on the upper jaws. In one instance, a temporary resection of both superior maxillæ (Kocher), he had tied both external carotids with excellent result.

DR. LILIENTHAL called attention to the advisability of the surgeon calling in a dentist before operating on a case of this kind. If the dentist was given the opportunity of looking over the ground beforehand, he knew about what he had to do and could get his mechanical appliance pretty well under way, whereas if we waited too long, the fitting of a prosthetic apparatus might be attended with difficulty. The speaker said he had seen cases where the deformity left after removal of both upper maxillæ was absolutely uncorrectable.

DR. KILIANI in closing, said that his patient had for a time after the operation complained of a severe unilateral headache on the side where the external carotid was ligated. It had eventually disappeared entirely. In reply to Dr. Lilienthal's suggestion, Dr. Kiliani said that a dentist had been called in to see the patient before the operation, but he had offered no suggestions, and said he would do nothing until the jaw had been removed.

THE VALUE OF WOLFE GRAFTS AND TENDON-LENGTHENING IN THE TREATMENT OF CICATRICAL CONTRACTURES.

DR. CHARLES N. DOWD presented a paper with the above title (for which see page 278).

In connection with his paper, Dr. Dowd presented two patients upon whom he had operated by the method described. The history of these cases was contained in his paper.

DR. DAWBARN said he wished to emphasize the following points in reference to tendon-work only: In splicing ten-

dons, he thought it advisable to remove as much of the sheath as possible. Excepting right at the fold of the finger, where a short portion must be left, the sheath elsewhere was the enemy of the surgeon, and with its free removal there was less plastic exudate to deal with—less gluing fast by teno-synovitis. The use of Johnson & Johnson non-adhesive gold-beater's skin court-plaster to prevent adhesions between the tendons—as first recommended by Dr. Robert Morris. The speaker mentioned two personal cases in which there was sloughing of one of the tendons of the finger not far from its insertion (in one of them for a distance of nearly two inches), and in order to get a satisfactory result he had cut into the wrist high up, near the muscular juncture, and then, after finding the right tendon, it was severed extremely obliquely, so as to make a very long splice, and seizing its end in the other wound (that in the finger) it was drawn down until it came in contact with its opponent on the opposite side (*i. e.*, toward the finger-end) to which it was united by suturing. So far as the speaker was aware this plan has not elsewhere been employed.

Dr. Dawbarn said that in two cases of tendon-grafting, he had used tendons obtained from the leg of a cat. One proved successful; the other was a complete failure; the graft, about an inch long in both instances, having sloughed, in this second trial. However, as tendon is nourished only by vitalized plasma, and not directly by vessels of its own, such heteroplastic grafts deserve a better trial than they have heretofore received.

DR. LILIENTHAL said that in his own experience with these cases he had found that the success of the operation depended largely upon the complete excision of all the cicatricial tissue, followed by the application of Thiersch grafts of considerable thickness, but not through the full thickness of the skin. He recalled two cases, one of cicatricial contracture of the axilla and the other of the elbow, following burns, in both of which the parts were firmly bound down. In each case he excised the scar completely, until the motions of the limb were perfectly free, and then, after applying grafts by the ordinary Thiersch method, the arm was put up in the extended position, and in both instances he obtained a perfect result. The Thiersch grafts employed for

this purpose should not be of the very thinnest kind, nor should they include the full thickness of the skin, as the Wolfe graft did. The removal of the cicatricial tissue should be by thorough excision; simply denuding the surface or scraping away the granulations would not be satisfactory.

DR. KILIANI said that in the case of the child with the contracture of the elbow shown by Dr. Dowd he would be interested to learn how the Thiersch grafts behaved after two years had elapsed. Fifteen years ago, in the case of a severe burn on the inner surface of the arm, he had applied skin-grafts by the Thiersch method, and within four months the grafts had shriveled up to such a degree that they were removed without difficulty, while at the same time the sound skin had stretched to such an extent that its edges could be brought together. The speaker called attention to the fact that the skin-grafts contained no elastic fibres, and on that account shrinkage occurred.

DR. DOWD, in closing, said he had seen very annoying shrinkage occur in Thiersch skin-grafts, and for that reason thought it better to employ grafts of greater thickness. Kennedy's case, above referred to, is an important illustration of the relative value of the two varieties of grafts. He had employed the Thiersch and the Wolfe grafts side by side, marked contracture occurred in the former, but not in the latter. He believed that in the majority of cases of cicatricial contractures about joints the Wolfe grafts were much better than the Thiersch.

THE VITALITY OF RUBBER; WITH A NEW DEVICE REGARDING ITS LONGEVITY.

DR. DAWBARN said that he had investigated this subject, which was of some moment to the surgeon, and he had been informed by dealers that one of the best methods of preserving rubber articles was to keep them immersed in water. Of course, grease of any sort is fatal to rubber, as every one knows. Exposure to air, and quiescence, too, resulted in commencing crystallization, which was the beginning of the death of rubber. Many years ago, Dr. Gerster had informed him that in order to prolong the life of his rubber tourniquet, whenever he opened the closet where it was kept he took occasion to give it a good stretching. All bicycle-repair men advise, too, that a rubber tire should be

kept pumped up as hard as possible during the winter months of the bicycle's disuse; and that persistent deflation soon results in a rotten tire.

Obviously, maintenance of a persistent slight pull, to keep a rubber tube "awake," is better than semi-occasional stretchings at irregular intervals. And the object of these remarks was to show to the Society a pair of clamps, obtained from Ermold & Co., in this city, by which without cutting into the rubber the two ends of the large tubing we use for cording limbs are seized. One of these clamps is caught over a nail high in the closet; the other at the lower end, has a light weight attached to it. Thus the tubing is always subject to some little degree of tension.